Initial Approval: October 12, 2016

CRITERIA FOR PRIOR AUTHORIZATION

Incretin mimetic agents

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) require prior authorization:
Lixisenatide (Adlyxin®)

CRITERIA FOR INITIAL APPROVAL FOR LIXISENATIDE: (must meet all of the following)

- Patient must be at least 18 years old.
- Patient must have a diagnosis of Type 2 Diabetes.
  - Diagnosis of Type 2 Diabetes must be documented by HbA1c > 6.5%
- Patient must have HbA1c between 6.5% - 9.0%
- Patient must have history of another diabetic agent in the previous 30 days (see table for examples of drug classes).

CRITERIA FOR RENEWAL FOR LIXISENATIDE: (must meet one of the following)

- Documented improvement of HbA1c from pretreatment levels
- Achievement or maintenance of therapeutic goals (HbA1c $\leq$ 6.5%)

LENGTH OF APPROVAL: 6 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE DATE

Examples of Diabetic Drug Classes
Biguanides
Sulfonylureas
Meglitinides
Thiazolidinediones
DDP-4 Inhibitors
Alpha-Glucosidase Inhibitors